STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155304	A. BUILDING _____ B. WING _____	C 01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF NEW CASTLE THE	**1000 N 16TH ST NEW CASTLE, IN 47362**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint number IN00101285.

Complaint number IN00101285 unsubstantiated due to lack of evidence

Survey date: January 5, 2012

Facility number: 000201
Provider number: 155304
AIM number: 100267910

Survey team: Leslie Parrett RN

Census bed type:
SNF: 2
SNF/NF: 50
Total: 52

Census payor type:
Medicare: 19
Medicaid: 18
Other: 15
Total: 52

Sample: 3

The Waters of New Castle was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint number IN00101285.

Quality review completed 1/9/12
Cathy Emswiller RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE